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RESEARCH ARTICLE

THE ROLE OF COMMUNITY-BASED ORGANIZATIONS ACHIEVING SUSTAINABLE DEVELOPMENT GOAL 3 IN DIOURBEL / SENEGAL

¹Mamadou Saliou Mbengue, ²El Hadji Madior Diop, ³Abdou Aziz Ndiaye and ⁴Christine Awa Diouf

^{1,2,3}Ph.D., Alioune Diop University of Bambey, Senegal; ⁴PhD student, Alioune Diop University of Bambey, Senegal

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*Corresponding author:

Eulália Artur Langa Nhanombe

ABSTRACT

To achieve the Sustainable Development Goals (SDGs), governments expect communities to participate in all development programs. In Senegal, Community-Based Organizations (CBOs) are involved in health development strategies in order to contribute locally to the achievement of Sustainable Development Goal 3 (SDG 3) dedicated to health. The aim of this study is to analyze the role of CBOs in the Diourbel commune in achieving SDG 3. A quantitative survey via a questionnaire administered to representatives of 39 CBOs followed a qualitative study via 10 individual interviews and 01 focus group of 08 targets. 39 FBOs, including 12 community watch and alert committees (CVACs), 09 health development committees (CDSs), 09 community health mutuals (MSCs) and 09 community-based organizations (CBOs) took part in the study. Respondents were predominantly male (72%), with an average age of 50. The study revealed limited knowledge and low appropriation of the SDGs and the Emerging Senegal Plan (ESP) by the CBOs. Depending on their activities, which are essentially health and socio-economic, the role of FBOs in health can be situated at three levels: prevention and health promotion, early and equitable access to quality health services, and social protection. This study shows that CBOs in the Diourbel commune play a vital role in local and sustainable health development. Their activities are perfectly in line with the targets of the national health objectives, which are aligned with those of MDG 3. However, the lack of financial resources hinders their smooth operation.

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INTRODUCTION

Since the 1970s, numerous strategies have been put in place to improve the health of populations. On September 12, 1978, the international conference on PHC held in Alma-Ata stressed the need for urgent action by all governments, health and development workers and the international community to protect and promote the health of all the world's people (1). Over the years, government authorities have noticed that the success and sustainability of health programs are strongly linked to the level of participation and commitment of the population. It was therefore essential to involve them in all stages of resolving their health problems. This is how the notion of community participation gradually became an essential principle of health development strategies. In the 1980s-1990s, this conference led to a major reform of health system management, following a meeting of African health ministers in Mali (Bamako). was the Bamako Initiative, which provided for a number of changes in the health system, including the creation of management committees to involve communities in the health effort (1). According to Jetté, it was in these years that community organization, which has its roots in *settlement houses*¹ took off, as people began to organize to support

governments, which were struggling to carry out the functions devolved to them after the economic crisis of the 1980s (2,3). In Senegal, communities became increasingly mobilized and organized at this time to take over some of the State's functions. There was a proliferation of entities bringing together populations with whom the government entered into partnership to survive the economic crisis (4). By the 2000s, improvements in health had been noted, but the international community realized that much remained to be done. In September 2000, the Millennium Summit, which brought together the world's governments at the United Nations, produced an agenda defining the 8 Millennium Development Goals (MDGs) to be achieved between 2000 and 2015. Despite the considerable achievements made, disparities were still present when the deadline arrived (1). In September 2015, the 193 UN member states agreed to achieve 17 goals to improve global health by 2030. Among them, SDG 3 entitled "empower people to live healthy lives and promote well-being at all ages" is specifically dedicated to health and well-being. Its aim is to combat inequalities, and it mainly concerns mothers and children, the fight against epidemics, road safety and access to healthcare (5, 6). It sets out 9 measurable targets to be achieved by 2030, and takes into account the curative, preventive and promotional aspects of health. Achieving it requires a participatory approach and a contribution from all sectors and disciplines. This requires, among other things, the effective involvement of communities, which can be achieved through the various bodies that represent them. In this regard, Neupane emphasized that "the 2030

¹Organizations created by groups of activists and militants from affluent backgrounds to alleviate the problems created by galloping urbanization and industrialization in working-class areas around the 19th century.

Agenda and the SDGs encourage national and international organizations to partner with civil society organizations (CSOs) and policy research institutions that work with communities and citizens to promote inclusion". She added that "organizations working with citizens, marginalized groups, and women could help promote community participation and health for all" (7). In Senegal, the Plan Sénégal Emergent (PSE)² is the reference document for the country's economic and social policy. It is structured around 3 axes for inclusive development and has the advantage of being in phase with the 2030 Agenda, which should enable Senegal to achieve economic and social development by 2030 (8, 9). In this respect, the country's governmental authorities, aware of the major asset that civil society represents in the process of implementing the SDGs and particularly SDG 3, are planning a special role for it in the national development program (10). People can make a valuable contribution through the various organizations that make up civil society, and community organizations in particular. In the commune of Diourbel, as in the rest of the country, various directives are being introduced to contribute locally to the achievement MDG 3. Special resources will need to be deployed by the commune, especially as it is faced with a shortage of health facilities. It will therefore be necessary strengthen the preventive and promotional aspects of health care, which is why community organizations can be so useful. These organizations are well established in the area, and some are specifically involved in local health development. How do they do this? How do these community organizations contribute to the development?. Health in the community? To what extent can they be said contribute to the achievement of MDG 3? This study is a response to these questions, with the aim of analyzing the role of the Diourbel commune's FBOs in achieving MDG 3.

METHODOLOGY

Study framework: The survey was carried out in the commune of Diourbel, capital of the Diourbel department, located in the Diourbel region in central-western Senegal. It comprises 4 major districts: Cheikh Anta Mbacké, Keur Cheikh Ibra Fall, Médinatoul (Keur Goumack), and Thierno Kandji (11). The commune's census population in 2023 was 2,080,811. people, including 1,029,953 men and 1,050,858 women (RGPH, 2023). In terms of health facilities, by 2021, the commune will have a hospital, a health center (CS) serving 09 health posts (08 public and 01 private), 04 doctors' surgeries and 05 paramedics, 03 clinics, 09 community health mutuals, and a hygiene brigade. According to the departmental youth service, between 2015 and 2017, there were 128 OCs in the commune, spread across its four main districts. We also note the presence of several informal CBOs, 73 of which were awaiting their receipt in 2020. In the same year, 43 FBOs divided into 4 types worked with the health center and its 9 public health structures. These were CVACs, MSCs, OCBs and CDSs, which replaced health committees (CS) in 8 of the 9 health facilities. In this study, we will sometimes refer to them as CDS/CS.

Type of stade : This was an exhaustive mixed study with a sequential design: first, a quantitative survey was carried out using questionnaires. Then, a qualitative study and a literature review were carried out to complement the results obtained through the questionnaires.

Data collection and analysis: Quantitative data were collected by means of a questionnaire administered to various representatives of the CBs, with several items. Data from the questionnaire were entered and processed using Excel. The results were tabulated and analyzed. Individual interviews and one focus group interview were also carried out. In-depth semi-structured interview guides and a focus group moderator' guide were adapted to the specific needs of each participant. The interviews were used to better understand, among other things,

the organization of FBOs, how they operate and their contribution to health development. The interviews were all conducted face-to-face, recorded on audiotape using a laptop and transcribed verbatim and/or translated for those conducted in the local language (Wolof). A content analysis was then carried out to identify typologies. All the information gathered through interviews, questionnaires and literature reviews was triangulated before being analyzed.

RESULTS

A total of 39 CBs, including 12 CVACs, 9 CDS/CSs, 9 MSCs and 9 OCBs, were included in the study. Not all types were represented in the various health posts. MSCs were the most present, although not the most numerous.

CBO organization, operations and activities: Between 2018 and 2019, CSs were replaced by CDSs following the January 2018 decree. In our study, only one health post that was a medico-social center attached to the Diourbel Red Cross was not affected by this reform. In 2020, 376 legally recognized associations residing in the health post's coverage area (neighborhood associations, women's promotion groups, community health mutuals, youth associations, sports and cultural associations) were represented in the CDSs. Together with 2 members from the mayor's office, local leaders such as religious chiefs and neighborhood delegates, 2 members from each of these associations made up the CDS general assembly, representing the population in their dealings with the health facilities. Members paid neither membership fees nor dues, but had to live in the locality and be available. The CS of the Red Cross health post no associations, and only 3 members, all from the departmental Red Cross committee. The election of the executive board and the coordination of activities were carried out through general assemblies, co-management and information meetings.

Various activities were carried out by the CDS/CS.

CDS activities focused on providing logistical and human resources support to health facilities in their awareness-raising activities, which mainly concerned malaria, tuberculosis (TB), family planning (FP), pre- and post-natal consultations (CPN/CPON) and Covid 19, as well as improving attendance at the health facility they also managed. In terms of human resources, 59% of health facility staff were recruited by the CDS/CS and the remainder by the State and the Town Hall. This so-called community staff mainly comprises nurses, nursing assistants, midwives, ticket sellers, community health workers, janitors, drivers, etc., and is paid by the CDS/CS from ticket and drug sales. Income-generating activities collective benefit have been curbed by the advent of Covid 19.

MSC organization, operations and activities: The MSCs we studied were accredited by the departmental union, and a board of directors, an executive committee, a general meeting and a supervisory body. They are responsible for guaranteeing social protection for their various groups of members/beneficiaries. Of the 9 MSCs that worked with local health facilities, only 2 included all member groups. A total of 44532 people were enrolled in the 8 MSCs. The majority were women. The most represented group was the BSFs (47.81%), followed by the classics (46.64%). CMU-Daara beneficiaries (0.23%) and CEC holders (0.5%) were the least present in the 8 MSCs. This can be explained by the fact that the inclusion of CMU-Daara beneficiaries is not fully effective at the MSC level, and that CEC holders were rare. The election of the board of directors, the executive committee and the coordination of activities were carried out through elective and ordinary general assemblies. Each MSC was represented at the level of the departmental union (UD) and regional union (UR) of Diourbel mutual, which supported their operations. Every month, invoices for services provided health facilities and pharmacies were paid, and the data collected and forwarded to the UD. MSC activities are divided into two groups (Table 2). As data on the monitoring of benefits by type of beneficiary and by health facility in 2020 was not available for 6 of the 9 mutuals data analysis

² The Plan Senegal Emergent (PSE) was adopted in November 2012 by the Senegalese government and its partners, with the aim of achieving economic emergence by 2035.

Table 1. Types activities offered by CDS/CS in 2019-2020

	Activities	Nb. City
	Wrestling	1
	Cultural evening (Ngel, Faux lion)	3
Activities generating of revenues	Soccer match	2
	Fair	2
	Caravan	4
Awareness-raising activities	Home visits (VAD)	9
	Talks	9
	Payment of water and electricity bills	9
	Structural maintenance, refurbishment of premises	9
	Purchase and maintenance of operating equipment	9
	Buying drugs	9
Health structure management	Human resources management, Partner search	9
	Organization of meetings and preparation of reports	9
	Sanitation	3
Group utility activities	Reforestation	1
	Blood donation	1

Table 2. Breakdown of MSC activities studied in 2020

	Activities	Nb. City
Income-generating activities	Soccer tournament	1
	Caravan	4
Awareness-raising activities	Visits to schools, Daara and workplaces	2
	VAD (home visits)	9
	Talks	9
	Local payment and electricity / head office maintenance	9
	Purchase/maintenance of operating equipment	9
	Mutual fund manager payment	9
MSC management	Payment invoices from services of which members benefit	9
	Data collection, organization of meetings and preparation of reports and minutes	9
	Participation UD and UR activities	9
	Partner search/advocacy	9

Table 3. Distribution of CB resources by type and category

OC	Internal resources	External resources
CDS/CS	Revenues from tickets and medicines Resources generated by their activities	Support from goodwill Mayoral subsidy (fund) Red Cross subsidy (for CS)
HVAC	—	—
MSC	Membership dues Resources generated by their activities	State subsidy Support from departmental union of mutual societies Support from volunteers
OCB	Membership dues Resources generated by their activities	Support from partners

based on available data. In terms of awareness-raising activities, main themes addressed were mutuality (membership, functioning and importance of mutuals) and civil status (civil registration, importance of civil registration). The MSCs also provided support to health facilities in their awareness-raising activities on malaria, TB, FP, ANC/CPON and Covid 19. Mutuality promotion agents or marketing agents trained by the UD and relay members of the MSC carried out the activities in collaboration with community players in the health facilities.

CVAC organization, Operations and activities: The first CVACs studied were born in 2017, but 75% were set up from 2018 onwards. They brought together volunteer members of the population trained to actively search communities for cases linked to 9 diseases which are: measles, polio, bloody diarrhea, meningitis, yellow fever, neonatal tetanus, cholera, Ebola and most recently Covid 19. Also, "events", such as repeated deaths in a neighbourhood or concession, were reported. This surveillance was carried out through VADs, during which awareness-raising sessions were held. The CVACs were headed by a chairman and deputy chairman, who, unlike the other members, had to be able to read and write in French. They were

under the responsibility of the ICP and had supervisors at regional level. Members of the 12 CVACs studied included village chiefs, community health workers, religious guides, local leaders, students, etc. Cases were notified to the CVAC chairman or deputy chairman. The suspected person was referred to the ICP after investigation by the chairman or his deputy, if confirmed and treated or referred to a higher level. If the suspected pathology was Ebola or Covid19, notification was made the health post and the ICP himself carried out the investigation to confirm or refute the diagnosis. After confirmation of a suspected case, follow-up was ensured until recovery, and more detailed surveillance was carried out in the area the case was detected. These were recorded in a register kept by the CVAC chairman, and monthly meetings were held for all CVAC members, as well as with the respective ICPs and the regional supervisor, for updates. In addition to daily monitoring through the VADs, talks, awareness caravans and radio broadcasts were often held. But in 2020, the talks and caravans could not be carried out because of Covid 19. Between 2018 (start of CVAC activities) and 2020, 19 suspected cases were recorded by the 12 CVACs and 04 cases were confirmed. In 2020, there had been almost no surveillance due to Covid 19, and all the CVACs had stated that since the start of

the year, the structures were no longer working as they had before. In 2019, there were 91 CVACs in the Diourbel health district, including 29 in the commune and 62 in rural areas. In 2020, only 15 CVACs were in operation at commune level, and 12 had participated in the study.

CB resources: FBO resources fell into two categories: internal and external.

Functional difficulties encountered by CBs: Overall, the difficulties encountered by FBOs financial in nature. Among the CDS/CS, the heavy burden on the organizations, particularly those relating to the management of health facilities (see Table 1), was the first to be highlighted. This, combined with a lack of inadequacy financial support from local authorities, was a real problem for all CBs of this type. For the MSCs, financial problems were mainly due to delays in government subsidies and membership fees. The heavy burden of managing these organizations (Table 2) was also highlighted. In addition, the abuse and fraud of benefits by beneficiaries, especially among TSOs, were strongly denounced. As far as the CVACs are concerned, the reduction and/or cessation of activities due to a lack of follow-up on the part of the project managers were the first to be denounced. At the outset, cell phones were allocated to CVAC presidents with monthly allocations of telephone credit to facilitate communication. Also, information meetings and talks between members were held every month. But from 2019 onwards, most of the cell phones were spoiled, phone credit allocations suspended and meetings not held. All this combined with the lack of motivation among members, who in a certain

At the time, they were using their own resources to ensure the continuity of their activities, leading the lethargic situation of the CVACs in 2020. Among CBOs, the lack of partners and delayed funding in the case of partnerships were the major problems. In most cases, donors do not pre-finance project/program activities. Funds are not available until after the activities have been carried out, and are generally late in being disbursed. CBOs are then obliged to draw on their internal resources (membership fees, income generated by activities) to carry out activities. Since these resources are limited, and members are unpaid, most CBOs did not carry out any activities without a partnership.

Knowledge of the SDGs and the PES: Almost half (46%) of the CBO representatives had never heard of the SDGs, and 42% of those who had heard of them said they didn't know exactly what they were. With regard to the PES, only 1 of the 39 representatives claimed to be unfamiliar with the subject; this was CBO president. All respondents who had heard of the SDOs had also heard of the PES (i.e. 54% of respondents). But of all the respondents who had heard of the PES, 45% were unfamiliar with the term ODD. CVAC were the most likely to have never heard of the SDOs (50% of all CB representatives not familiar with the term), while MSC and CDS/CS representatives were the most likely to have heard of them (33% and 28.5% respectively of all CB representatives familiar with the term).

The majority of those who claimed to have heard of the SDGs (57.15%) said they didn't know whether or not there was a link between the SDGs and health. Those who confirmed the existence of a link between the two (42.85%) said that this was self-evident, since health comes first when we talk about development. However, 60.5% said there was a link between PES and health, compared with 39.5% who said they didn't know whether or not there was a link between the two.

Among those who found a link between the two, 43.5% mentioned the free health care policies (0-5 years, caesarean section, dialysis, Plan Sesame) through universal health coverage (CMU) and mutual health insurance. Of those respondents who had heard of the SDGs and the PES, 57.14% said they didn't know whether or not there was a link between the SDGs and the PES. However, 12 representatives affirmed that there was a link between the two, specifying that both had development as their goal, and that the PES enabled the implementation of the SDGs at local level.

DICUSSION

Lack of information and archiving of data relating to CB activities was the biggest problem we faced during data collection. As a result, we were unable to carry out an outcome evaluation due to the lack of certain data and indicators. But despite this problem, we set out to review the essential aspects of our study in order to arrive at these results. Also, the CBOs of the rural and private health structures, as well as some CBOs which, although not in partnership with the municipality's health structures, carry out activities in the health field, were not taken into account. This is a limitation of our study.

Limited information on SDGs and PSE: With regard to knowledge of the SDGs, the survey results revealed that the concepts and notions associated with them were not very well known among the study population. Almost half (46%) of respondents had never heard of SDGs; only 31% said they had heard of them but knew what they were, and 23% had heard of them without really knowing what they were. These results were confirmed in the interviews conducted, where almost all respondents said they had never heard of SDGs, and some only had a basic understanding of the subject: *"We just hear about it, but we don't know anything about it. It's useless to us, we're not involved in it."* declares Mr. T.S. / CVAC; "It's for development at country level" according to M.M.D. / MSC. These low results are still better than those of a study carried out in 2021 on citizens' perceptions, attitudes, behaviours and feelings about international solidarity issues where the responses obtained in France, Germany, the United States and the United Kingdom revealed that the majority of respondents (51% to 76%, depending on the country) were sure they didn't know what the SDGs were; only a small proportion (7% to 11%) said they had already heard of them but knew what they were (13). In contrast to the SDGs, a good level of awareness of the PES was noted among respondents. Of the 38 out of 39 respondents who said they had already heard of the PES, 29 claimed to know what it was, and 9 said they have no idea about the subject or were not interested in the PES, which they took for purely political issue. During our interviews, the trend was much the same. All respondents said they had already heard of the PES, even though almost the half said they didn't know what it was. During the group interview, K.L., a member of a CVAC, agreed with the majority of participants when he said: "We don't feel concerned by the PES."

As community stakeholders, we've never been involved in it. *We've heard that the recent infrastructures: roads, stadiums and buildings in Diamniadio were built within this framework. We don't even know what it's all about".* Thus, we can't feel being involved in it, just as it had been denounced by the respondents with regard to the SDGs, was also present with regard to the PES. As far as the link between the SDGs and the PES is concerned, the comments of those who said they found a link between the two (42.86%) focused on the scale of implementation and the purpose of the two concepts. The comments made during interviews were the same: *"People are at the heart of sustainable development, so apart from the environment, health is essential, it's a very important area. We need to prioritize access to quality healthcare. Health occupies a prominent place in the SDGs."* "There's the macro aspect, the highest level (SDGs)" and the micro aspect, the local level (PSE). *The SDGs are at international level, and the PES enables the SDGs to be achieved at national level"*, said D.C. / OCB and Y.S. / CDS respectively. Our study revealed gaps to fulfil in the respondents' knowledge of the SDGs and the PES. Even if some were informed on the subjects, the latter suffered not only from a lack of dissemination but also of appropriation among the study population. The majority of them had expressed the need to be better informed and involved in these issues during the interviews. Better knowledge in these areas would enable them to better orient their activities and interventions, but also to better inform the population on these issues, in order to encourage greater appropriation of these development models by the population.

Activities related to national guidelines and the health needs of communities and healthcare facilities: The activities carried out by FBOs are generally in the health and socio-economic fields.

Awareness-raising activities are more frequent and generally of the VAD/VADI or VALT type, with talks, caravans and community mobilization on a variety of themes and targets. In the case of CBOs, they are mainly carried out in case of malaria, tuberculosis, covid19, HIV, ANC/CPON, FP, vaccination/EPI and nutrition. During the interviews, respondents clarified the choice of these fields. H.B.C., one of the Nurses in Chief interviewed, said: *"We work on the basis of the programs of the Ministry of Health and Social Action. According to Senegal's health development plan and the diseases identified as priorities, we draw up a roadmap adapted to the realities of our populations. It's this roadmap that we roll out throughout the year, and the activities we carry out are part of this framework"*. When we look closely at this National Health and Social Development Plan (PNDSS), we see that in Senegal, efforts are still needed in the areas of maternal and child health, communicable and non-communicable diseases (14). As a result, these areas have been targeted in Senegal's national health objectives, and some have been included in the activities planned for players at community level (15). On top of the list are maternal, neonatal and child health, where vaccine-preventable diseases, malaria, acute respiratory infections (ARI) and malnutrition are taken into account. Then HIV/AIDS, TB, malaria, epidemic diseases under community-based surveillance and neglected tropical diseases are taken into account in the field of communicable diseases. Non-communicable diseases include diabetes, cardiovascular disease, cancer (breast, cervical and liver) and chronic lung disease. And finally, water, hygiene and sanitation sectors are included. So, it would seem that the areas in which the CBOs studied are active are well aligned with national health priorities. These activities are carried out in direct collaboration with the health facilities that request them. During VADI and VALT, awareness-raising is accompanied by services such as weighing, vitamin A supplementation, deworming and diagnosis of malnutrition in children, as well as the distribution of SP as part of IPT to pregnant women to prevent malaria. As for HIV/AIDS and sometimes Covid 19, awareness-raising activities are carried out by CBOs with donor funding, but always through health facilities. Also, in the context of Covid 19, awareness-raising activities, whether or not financed by donors, are often accompanied by donations of food and cleaning products. Awareness-raising activities on malaria and tuberculosis are almost always carried out within the framework of two projects run respectively by the NGOs Plan International and EMAD, financed by the Global Fund. The CBOs working on these projects are the sub-recipients, but do not collaborate directly with the recipient NGOs. The latter work through the health structures, in particular the health center, with which they sign an agreement and which is then responsible for selecting the CBOs with whom the activities are to be carried out. The aim of these projects is to reduce morbidity and, above all, mortality linked to tuberculosis and malaria, with a view to their eradication in Senegal by 2030. Topics covered include the causes, signs, treatment and prevention of diseases. In addition to raising awareness, malaria prevention activities include the destruction of breeding grounds, and tuberculosis prevention involves active research and referral of chronic coughers. On this last point, Mr. Y.G., community supervisor for this program, explains: *"Our objectives are no longer limited to raising awareness. Beyond that, we aim to identify patients and suspects and refer them to health facilities for early and appropriate care"*.

At the same time, community surveillance is carried out to detect sick people in the community. This community-based surveillance of diseases with epidemic potential, with referral of cases, is the main activity of the CVACs. Awareness-raising on the diseases concerned and/or detected during surveillance is also carried out. Among MSCs and CDSs, in addition to the importance of frequenting health facilities and, above all, using them early, mutuality and civil registration are addressed during awareness-raising activities. Collective and income-generating activities are also carried out by the majority of CBOs, MSCs and CDSs. These activities include blood donation days, reforestation or cleaning days, other microfinance activities, donations of food, clothing or cleaning products, training activities, and school or vocational support. CBOs are more active in the processing or local manufacture and sale of food or cleaning

products, as well as in the rental of event equipment. CDSs and MSCs are more involved in organizing sporting or socio-cultural activities. MSCs and CDSs carry out income-generating activities to raise funds to support their management costs. CBOs, on the other hand, do so mainly to provide financial assistance to their members, to finance their own activities in case of lack of partnerships, and to pre-finance their activities in case of delays in funding. The activities of the CBOs vary, but above all they are complementary. During interviews, the respondents stated that if the FBOs were to make a major contribution to health, it would be because their activities were carried out at different levels and complemented each other. The head nurse, H.C.B. commented: *"It's difficult for us to achieve our objectives without the support of these CBs. Each plays a decisive role at his or her own level. The CDSs are essential to the smooth running of the structure. They help us to have a good technical platform and to provide quality services to the population. Thanks to the activities carried out by the CBOs and CVACs, we've seen an increase in the number of people using the structure, as they're better informed and more aware of their state of health. And thanks to the MSCs, which offer people many more possibilities for treatment, they come to the facility regularly and on time, which avoids complications"*. In the various speeches collected, the increase in the use of health facilities by the population and the early recourse to health services were recurrent themes for all types of FBO. With regard to the CDS, EL.M.S. One of the nurses in chief interviewed, stated: *"A lot has been achieved in the health post thanks to the collaboration of the CDS, based on the income-generating activities it carries out. But it's important to point out that, at grassroots level, it's the population itself that takes action. If I take the example of the ultrasound machine, it was purchased thanks to a contribution of one million francs CFA from a well-intentioned member of civil society. Also, when we organize cultural and community activities, the communities contribute with their own money. However, it's thanks to the CDS, which makes a good advocacy to the population and initiates and coordinates all fund-raising strategies"*.

For the CVACs and OCBs, all discussions were geared towards improving the population's knowledge of the most common diseases: *"We don't want to brag, but we can say that almost 65% of the population who didn't go to the health facilities do so thanks to our interventions. The truth is, people aren't refusing treatment, it's just that they lack information about the diseases. But since we've been raising awareness of certain diseases and talking to them about the importance of seeking care early, we've seen a massive increase in the use of health facilities. For example, we used to have a high mortality rate from malaria in our community, because she used to confuse severe malaria with yellow fever. What's more, they thought that malaria treatment was more expensive in the facilities, so they preferred to go to traditional practitioners for treatment. However, thanks to our interventions, she is now better informed about the symptoms, signs and treatment of diseases, and about the importance of seeking treatment in health facilities. What's more, when a patient is referred by a CVAC, he or she doesn't have to pay for the consultation and the medicines available"*, said the C.A.D. / CVAC respondent.

ICP F.B.C declared: *"The OCBs are a great support to the health structures. To take my own example, I'm a Nurse in Chief in this area and I come from another region. When I arrived, I knew nothing about this area. I went through the CBOs to reach my population and my health objectives. Also, the community has a lot of confidence in these CBOs, whose members come from the community. To reach them, it's important to go through them. And that's what NGOs and donors do. It's impossible for me to give a figure to show how much they contribute to achieving my organization's objectives, but I know that they are essential to me"*.

As far as the MSCs were concerned, the issue of social protection was a major topic of discussion. Like the members, the health staff had hailed the important role played by MSCs in guaranteeing their members access to social protection. It would seem, then, that the CBs are the intermediaries between the community and the health

structures. It's not easy to claim that all these effects reported by the respondents were assignable to the FBOs, but it's clear that they play a major role. In terms of their activities, the role of FBOs in health can be situated at several levels: prevention and health promotion, early and equitable access to quality health care and services, and social protection. These different aspects constitute the main components generally taken into account when defining health objectives, and are affected by FBOs. At national level, the health orientations described in the PSE and the PNDSS 2019-2020 are broadly related to these three aspects (10). These guidelines are set out in the part 2 of the PES, which focuses on "human capital, social protection and sustainable development". As the third part of the PES are perfectly aligned with the 17 SDGs of the 2030 Agenda, 9 SDGs, including SDG3 dedicated to health, are grouped under part 2 of the Plan. We can therefore say that the activities of CBOs are perfectly coherent with the targets of SDG3, which are also broken down in relation to these aspects of health prevention and promotion, equitable access to quality care and universal health coverage (10). In this way, CBOs contribute to the achievement of SDG3 through their participation in the national health objectives. It's important to point out that the PES is a step towards achieving the SDGs through its various parts, which allow them to be better integrated, even if there was a certain time lag between the two. However, the end of the PES will not be an obstacle to achieving the SDGs, insofar as it is merely a consolidation of the various programs already present in the country, which will continue to be implemented even if the PES is no longer relevant, and will therefore necessarily be in phase with the SDGs.

Operation hampered by many difficulties: The CBs face many problems when operating and doing their activities. Overall, they are financial. The lack of financial support or delay in subsidies from government and local authorities as well as the delay in financing in case of partnership were raised by the CBs. These restrictions are the source of almost all the problems they face. The CSD/SC unanimously denounced the lack of financial support from local authorities. The words of A.D. / CDS summed up well the situation they were faced with, "Health is a competence transferred to the town hall. We should receive annual endowment funds from him but since I've been here the position has only received one and that was in 2018-19." He added, "There is a note from the Ministry of Health that says that the state, through the town halls, should cover the costs of water and electricity for health posts but it's nothing like that." They have a lot to do with few resources. These come mainly from the sale of tickets and medicines and from these recipes, they draw to pay the costs of management of the health structure, buy the medicines of the pharmacy (IB) and pay the service providers that they recruited. In addition, health facilities are slow to receive the annual subsidies related to free access policies within the CMU, especially with regard to free care for children 0-5 years. Also, the MSC usually delay to reimburse the expenses of taking charge of their members to the health structures. All of this has an impact on the CDS. This delay in the refund of the health structures' benefits which the members of the MSC is due to a flagrant delay of the government subsidies and the contributions of the members combined with high costs linked to the management of the MSC. The government is responsible for 50% of the contributions of the traditional members and 100% of those of the BSF and CEC holders, and must repay these subsidies to the MSC annually. But, as pointed out by the respondent M.M.D / CVAC in his speech, this is not regular: «The last refund from the state that I received dates from 2017 and was not even complete».

In addition, the lack of an «inter-culture» among the populations mentioned in an article on the difficulties in coordinating the actors of health insurances in Senegal was also denounced by almost all the MSCs in our study (16). According to the latter, the populations do not join the MSC because they have difficulty in finding an interest in the pension and with those who joined, there are adverse effects in relation to the use of the benefits. The BSOs that are 100% supported by the MSC, abuse benefits and commit fraud, which increases the amount of invoices for benefits received by the MSC. And as they are

often in the majority in the MSC, do not contribute and that other groups of members are late in their contributions, this causes a lot of financial difficulties for the MSC. For CVAC, lack of follow-up is the main issue. At the time of the study, coordination meetings and capacity building sessions with head nurses were almost non-existent. Also, the communication tools used in particular mobile phones no longer worked. The statements made by the interviewees during the interviews were quite illustrative:

"CVAC no longer works. We work alone, forced to use our own resources to carry out our activities while we receive no motivation," said the K.L/ CVAC respondent.

Mrs. S.A.G. / CVAC added, "Sometimes we take our own money to motivate people who guide us because they don't even have enough to transport themselves from home to the healthcare facility. Sometimes they don't even have what to prepare meals for the day. You can hear them complaining that instead of asking them to go into the healthcare facility when they have nothing, it is better to bring them something that serves them in their daily lives. It hurts us, but we don't have the means to act". These problems reported by the populations in our study are similar to those mentioned in the qualitative survey on the motivations of 65 CVAC members involved in infectious disease surveillance in Senegal in 2019 (12). This talks about a feeling of inability to solve the populations' sufferings that drives CVAC. The same feeling was evoked by the OCBs who also suffer from a lack of partners and support.

CONCLUSION

The COs of the municipality of Diourbel generally play a key role in local and sustainable health development. Their activities are fully consistent with the targets of national health goals, which are aligned with those of SDG 3. Authorities are aware of the need to integrate them into development projects and programmes implemented for the population. However, there are limitations to this involvement. However, they face many difficulties in their operation, mainly of a financial nature. Also, gaps in their knowledge of the SDGs and PSE have been noted and are responsible for a lack of ownership of these; this can be a brake on the development of behaviours and conducive actions to the achievement of these development ideals. On the other hand, the lack of Information and data archiving related to CB activities identified by the study was the biggest problem we faced when collecting data. As a result of this work, it seems to be relevant to carry out further research involving the populations themselves. In this sense, it would be good to analyze the perception of populations on the contribution of community organizations in improving their health and living conditions more generally.

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